IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

PATRICIA ROWAN ROBERTS	:	
Plaintiff,	:	
	:	**CIVIL ACTION NO. 03-CV-1739**
v.	:	
	:	
INDEPENDENCE BLUE CROSS, ET AL.	:	
Defendants.	:	

MEMORANDUM AND ORDER

Tucker, J. **January _____, 2005**

Presently before this Court is Defendants' Motion for Summary Judgment (Doc. 18) and Plaintiff's Motion for Partial Summary Judgment (Doc. 19). For the reasons set forth below, upon consideration of the Parties' Cross-Motions for Summary Judgment and all responses thereto (Docs. 20 & 21), this Court will grant Defendants' Motion for Summary Judgment and deny Plaintiff's Motion for Partial Summary Judgment.

BACKGROUND

The parties agree upon all pertinent facts relating to this action. Plaintiff, Patricia Rowan-Roberts, suffers from pemphigus vulgaris, a systemic disease that is characterized by blistering and ulceration of the skin and mucous membranes, and similar symptoms. Pl's Brief at 1. Plaintiff suffered, and continues to suffer painful mucosci ulcerations and mucosci lesions. Id. Approximately four years ago, Plaintiff's teeth fell out due to the damage her disease did to the soft tissues of her mouth. Id. at 2. Plaintiff is now seeking compensation from her health plan and dental plan, which is provided by her employer and managed by the Defendants, for amounts paid to various dentists for dental implant services and replacement of her teeth.

On September 25, 2001, Plaintiff's provider, Dr. Wolfinger, wrote a pre-certification request

letter to Defendants as a medical claim for certain services to treat Plaintiff's pemphigus vulgaris. This letter advised Defendants that "[b]ecause pemphigus attacks the oral mucosa making it fragile, easily bruised and highly ulcerative, the use of a removable prosthesis is not appropriate and will be intolerable to the patient. For this reason, an osseointegrated orthopedic form of bone-anchored rehabilitation is required." Pl's Brief at 2. The Defendants denied pre-certification.

On October 31, 2001, Dr. Balshi performed surgery on the Plaintiff. Thereafter, Prosthodontics submitted several post-operative claims for services performed on Plaintiff's behalf to the Defendants. See Pl's Brief at 3. In response to those claims, Defendants informed Plaintiff that they were paying a total of $1,055.20 of the $100,396.00 billed for services provided. Id. The Defendants determined that the insurance plan approved tooth extractions, however, coverage for the panorex filming of the teeth, the prosthetic teeth, and the implantation of the prosthetic teeth was denied.

In response to the denial of coverage, Plaintiff, without the aid of counsel, wrote a letter dated February 25, 2002, to the Defendants asking for reconsideration of her claim. Pl's Brief at 4. On March 4, 2002, Defendants received Plaintiff's letter and assigned Annette Kirlin Jones as Clinical Appeal Coordinator to the claim. Id. In a letter written by Jones dated April 2, 2002, Defendants informed Plaintiff that the first level appeal decision upheld the prior decision that denied coverage. In this letter, Defendants stated that "the services performed are not covered under your insurance plan. Benefit exclusions for the requested service exist under this insurance plan. Although a given treatment may be deemed necessary or advisable by a treating physician, when benefit exclusions exist, coverage is not available under your insurance plan." Pl's Brief at 6, Exhibit R.

In a letter dated, April 5, 2002, Plaintiff requested an expedited second level appeal. Pl's

Brief at 6. Plaintiff also requested copies of the Defendants' clinical rationale used in the first appeal process, a copy of the board certified oral maxillofacial surgeon's report used in the first appeal process, and a copy of the Plan. Id. at 6-7. In response, Defendants scheduled a grievance hearing before the appeals committee by May 21, 2002. On June 25, 2002, Defendants held a meeting of the Second Level PPO Committee Meeting to review the Plaintiff's claims. Plaintiff appeared by telephone. In a letter to Plaintiff dated July 2, 2002, the Committee Representative, Kendra Nelson Robinson, explained the decision of the Second Level Appeals Committee. This letter provided, in pertinent part:

> Based on the information reviewed by the Committee on June 25, 2002, it was determined that the dental services requested are a specific benefit exclusion of your Personal Choice policy. Please review the *What Is Not Covered* section of your Personal Choice Benefits booklet/Certificate. This section states that *no benefits will be provided for services directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or disease of the teeth, gums or structures directly supporting or attached to the teeth, except as specifically stated under the coverage*. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolecomy, bone grafts or other procedures provided to augment an atrophic mandible or maxilla in preparation for dentures, and treatment of peridontal disease unless otherwise indicated. . . .
>
> Per your benefits, dental or oral surgery rendered by a professional provider and or facility provider will be a covered expense under this program only for surgical removal of impacted teeth, which are partially or completely covered by bone. . . .

Pl's Brief Exhibit 2 (emphasis added). Following this appeal, Plaintiff brought the instant action for compensation from her health and dental plan.

STANDARD OF REVIEW

1. Summary Judgment Standard of Review

Summary judgment is appropriate "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with affidavits, if any, show that there is no genuine issue as to any

material fact and that the moving party is entitled to judgment as a matter of law." FED. R. CIV. P. 56(c). An issue is "genuine" if the evidence is such that a reasonable jury could return a verdict for the non-moving party. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248, 106 S. Ct. 2505, 2510, 91 L. Ed.2d 202 (1986). A factual dispute is "material" if it might affect the outcome of the case under governing law. Id.

A party seeking summary judgment always bears the initial responsibility for informing the district court of the basis of its motion and identifying those portions of the record that it believes demonstrate the absence of a genuine issue of material fact. Celotex Corp. v. Catrett, 477 U.S. 317, 322, 106 S. Ct. 2548, 2552, 91 L. Ed.2d 265 (1986). Where the non-moving party bears the burden of proof on a particular issue at trial, the movant's initial Celotex burden can be met simply by "pointing out to the district court that there is an absence of evidence to support the non-moving party's case." Celotex, 477 U.S. at 325, 106 S. Ct. at 2553-54. After the moving party has met its initial burden, "the adverse party's response, by affidavits or otherwise as provided in this rule, must set forth specific facts showing that there is a genuine issue for trial." Fed. R. Civ. P. 56(e). That is, summary judgment is appropriate if the non-moving party fails to rebut by making a factual showing "sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial." Celotex, 477 U.S. at 322, 106 S. Ct. at 2552-53. "[I]f the opponent [of summary judgment] has exceeded the 'mere scintilla' [of evidence] threshold and has offered a genuine issue of material fact, then the court cannot credit the movant's version of events against the opponent, even if the quantity of the movant's evidence far outweighs that of its opponent." Big Apple BMW, Inc. v. BMW of North America, Inc., 974 F.2d 1358, 1363 (3d Cir. 1992). Under Rule 56, the Court must view the evidence presented on the motion in the

light most favorable to the opposing party. Anderson, 477 U.S. at 255, 106 S. Ct. at 2513-14.

2. Scope and Standard of Review for an Administrator's Decision to Deny Benefits

The Supreme Court stated that "a denial of benefits under [ERISA, 29 U.S.C.] § 1132(a)(1)(B) must be reviewed under a de novo standard unless the benefit plan expressly gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the plan's terms." See Stratton v. E.I. Dupont De Nemours & Co., 363 F.3d 250, 253 (3d Cir. 2004) (quoting Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 102, 103 L. Ed. 2d 80, 109 S. Ct. 948 (1989)). In cases where an administrator exercises discretion, the Supreme Court mandates review under the arbitrary and capricious standard. Id. at 254.

"Under the arbitrary and capricious standard, an administrator's decision will only be overturned if it is without reason, unsupported by substantial evidence or erroneous as a matter of law [and] the court is not free to substitute its own judgment for that of the defendants in determining eligibility for plan benefits." See Lasser v. Reliance Standard Life Ins. Co., 344 F. 3d 381, 384 (3d Cir. 2003) (quoting Pinto v. Reliance Standard Life Ins. Co., 214 F. 3d 377, 387 (3d Cir. 2000)). In this case, both parties agree that the arbitrary and capricious standard is applicable. Def's Brief at 4; Pl's Brief at 10.

If the same entity that determines whether a claimant is disabled must also pay for disability benefits, as is the situation in the instant case, there is a structural or inherent conflict of interest that mandates a "heightened" arbitrary and capricious standard of review. Lasser, 344 F. 3d at 385 (citing Pinto, 214 F. 3d at 378). This heightened form of review is formulated on a sliding scale basis, which enables the court to "review[] the merits of the interpretation to determine whether it is consistent with an exercise of discretion by a fiduciary acting free of the interests that conflict with

those beneficiaries." Stratton, 363 F. 3d at 254 (quoting Pinto, 214 F. 3d at 391). In employing the sliding scale standard, the court is to take into account the following factors in determining the severity of the conflict: (1) the sophistication of the parties; (2) the information accessible to the parties; (3) the exact financial arrangement between the insurer and the company; and (4) the status of the fiduciary. Id.

The burden of proof is on the claimant to show that a heightened standard of review is warranted in a particular case. Schlegel v. Life Ins. Co. of N. America, 269 F. Supp. 2d 612, 617 (E.D. Pa. 2003). In this case, the Plaintiff offers no evidence of conflict other than the inherent structural conflict, therefore, this Court finds that the correct standard of review is at "the mild end of the heightened arbitrary and capricious scale," and thus will afford a "moderate degree of deference" to the Defendant's determinations. Lasser, 344 F. 3d at 385. See Pl's Brief at 12.

DISCUSSION

The issue at bar is not whether Plaintiff's surgery to replace her teeth was medically necessary – Defendants have not challenged Plaintiff on this matter. Defs' Brief at 5. Rather, at issue is the Defendants' determination that Plaintiff's surgery is not covered regardless of medical necessity due to an explicitly listed exclusion in her policy. Defendants argue that despite the medical necessity, the plan selected by Plaintiff's employer specifically excluded all services directly related to the replacement of teeth. In rebuttal, Plaintiff argues that the Defendants' interpretation of the words "directly related" was arbitrary and capricious. Plaintiff submits that Exclusion 23, which is the exclusion in dispute, does not apply in this case because the treatment for which Plaintiff sought benefits was not immediately connected to dental services. It was simply a dental solution to a medical problem.

The first task of this Court is to determine, as a matter of law, whether the terms at issue are ambiguous, and if they are not, to give effect to their meaning. Martin v. Masco Indus. Employees' Benefit Plan, 747 F. Supp. 1150, 1153 (W.D. Pa. 1990). "ERISA health plans must provide participants with a plan document that clearly explains coverage." Bill Gray Enter., Inc. Employee Health and Welfare Plan v. Gourley, 248 F. 3d 206, 218 (3d Cir. 2001). A term is "ambiguous if it is subject to reasonable alternative interpretations." Id. (citing Taylor v. Cont'l Group Change in Control Severance Pay Plan, 933 F. 2d 1227, 1232 (3d Cir. 1991)). In determining whether a particular clause in a plan document is ambiguous, the Court must first look to the plain language of the document. "If the plain language of the document is clear, courts must not look to other evidence." Id.

Here, in reviewing the Defendants' interpretation of the plan, the Court must first examine whether the terms of the plan document are ambiguous. If the terms are unambiguous, then any actions taken by the Defendants inconsistent with the terms of the document are arbitrary, but actions reasonably consistent with unambiguous plan language are not arbitrary. Id.

The plan document explicitly states in "Section EX – Exclusions" that "[e]xcept as specifically provided in this Contract, no benefits will be provided for services, supplies or charges: [d]irectly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth, except as specifically stated in the Contract." Defs' Ex. 2 at 63-64. The plan language at issue could hardly be more clear in its exclusion of the coverage sought by Plaintiff. The Plaintiff points to a general provision in the Contract under "Section DB – Description of Benefits," which states that "[s]ubject to the ***Exclusions***, conditions and limitations of this Contract, a Covered Person is entitled to

benefits for Covered Services when: (1) deemed Medically Necessary and/or Medically Appropriate and (2) billed for by a Provider." Defs' Ex. 2 at 38 (emphasis added). As evidenced by this provision of the Contract, all claims made by Plaintiff under this Contract were subject to the enumerated exclusions. So as not to be ambiguous as to what is excluded, the Contract devotes five pages to detailing the types of surgeries and services not covered, even if medically necessary.

In an analogous case, the Plaintiff sought reimbursement for breast reduction surgery, which was deemed medically necessary by her physicians. Although medically necessary, the Court found that coverage was properly excluded under her insurance plan. Specifically, the Martin court stated that "[a] contextual argument has some initial appeal because one could hardly believe a medical plan would exclude coverage for reconstructive plastic surgery or similar medically necessary procedures." 747 F. Supp. at 1154. However, "the plan expressly addresses this concern by listing reconstructive surgery which is covered. Rather than being ambiguous, the plan goes into particularly specific detail." Id; see also Defs' Ex. 2 at 38-62.

Even under a heightened standard of review affording a moderate degree of deference to the Defendants, Plaintiff cannot manufacture an ambiguity here. Therefore, this Court, finding that a reasonable plan participant reading the above-disputed language would understand that the plan document clearly excludes the coverage at issue, holds that the Defendants' interpretation under the plan was not arbitrary and capricious. Bill Gray Enter., 248 F. 3d at 219. Consequently, this Court will grant Defendants' Motion for Summary Judgment and deny Plaintiff's Motion for Partial Summary Judgment.

CONCLUSION

For the foregoing reasons, this Court will grant Defendants' Motion for Summary Judgment

and deny Plaintiff's Motion for Partial Summary Judgment. An appropriate order follows.

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PATRICIA ROWAN ROBERTS	**:**	
Plaintiff,	**:**	
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v.	**:**	
	:	
INDEPENDENCE BLUE CROSS, ET AL.	**:**	
Defendants,	**:**	

ORDER

AND NOW, this ____ day of January, 2005, upon consideration of Defendants' Motion for Summary Judgment (Doc. 18), Plaintiff's Motion for Partial Summary Judgment (Doc. 19) and all Responses thereto (Docs. 20 & 21), **IT IS HEREBY ORDERED AND DECREED** that:

1. The Defendants' Motion for Summary Judgment is **GRANTED**.
2. The Plaintiff's Motion for Partial Summary Judgment is **DENIED**.
3. The Clerk of the Court shall mark the above-captioned case as **CLOSED**.

BY THE COURT:

Hon. Petrese B. Tucker, U.S.D.J.